psychogenic bodily pain (Merskey & Spear, 1967). A third is to relapse into depression itself.

Alternatively, defence mechanisms, such as denial of a loss, may prove sufficient to cope with the pain – at any rate for a while.

> *A middle-aged woman presented with depression. She knew that her father had died when she was 10; she thought she believed what she had been told as a child that he had been reported missing, presumed dead, on active service during the war. This allowed her to go on hoping that perhaps after all he was not dead and might one day turn up, so that for 30 years she had hoped every knock on the door might be her father. During psychotherapy she one day recalled with horror a memory of her brother coming into the kitchen when she was 10 and saying, 'There's a man in the garage with blood all over him.' At that moment she realized that her father had killed himself but simultaneously denied the knowledge; the memory remained, though buried, for years. Only by painfully accepting the fact of his death and its horrifying circumstances could she begin to work through the process of mourning and to move forward again.*

In the following section we consider further mechanisms of defence commonly used to manage anxiety

DEFENCE MECHANISMS

One way of dealing with aspects of the self that, if consciously experienced, might give rise to unbearable anxiety or psychic pain is by using a variety of defence mechanisms.

Everyone needs and uses defences at some time – the question is, 'to what extent and when?'. Sometimes, overenthusiastic workers in psychiatry or its fringes appear to feel that no one should have any defences, regarding them as a modern form of sin; but an uninvited attack on someone's defences is as unjustified as any other form of assault. Defences are normal psychological mechanisms and help to maintain an individual's mental stability. To attack them insensitively is likely to be harmful.

Defences are often categorized according to developmental stages – immature/early/primitive, neurotic, and mature (see Table 1). This is not to say that someone who uses immature mechanisms is an

Table 1 Mechanisims of defence

Primitive/immature	*Neurotic*	*Mature*
Idealization	Denial	Humour
Projective identification	Depersonalization	Sublimation
Splitting	Displacement	
Projection	Intellectualization	
	Rationalization	
	Reaction formation	
	Regression	
	Repression	
	Phobic avoidance	

immature person, more that we default to increasingly immature mechanisims as our anxiety increases and as we become more psychologically desperate and terrified about our mental survival. Maturity includes a capacity to acknowledge and tolerate problematic feelings and thoughts within ourselves without acting on them, except when appropriate. We gradually develop a separation between thinking and doing and no longer need to use early mechanisms of defence excessively as we develop more mature defence styles. Use of a more mature mix of defences is associated with better general adjustment (Erickson, Feldman, & Steiner, 1996) whilst recurrent use of more immature styles leads to psychiatric disturbance (Vaillant, 1992). Regression increases the risk of suicide and violence, displacement differentiates violent from non-violent patients, projection and denial turn aggression outward, and repression has been linked to inwardly directed aggression (Apter, Plutchik, Sevy, *et al.*, 1989). This supports the idea that some defences are more primitive than others, representing earlier developmental psychological processes which were appropriate at a specific stage of development. But when they are used inappropriately or excessively at a later stage of development this suggests underlying psychological disturbance. The more primitive mechanisms are considered to be splitting, projection, projective identification, omnipotence, and devaluation. In short, the sort of person who sees things in black and white and fails to take into account the views or experiences of others.

Freud (1894) first introduced the term 'defence' to describe the specific defence mechanism operating in the cases of hysteria he was then studying; he later termed this particular defence 'repression' and went on to describe others. Repression has been suggested to be the primary mechanism of defence and that other

defences are only called into operation when it fails and unacceptable impulses or wishes become more conscious – the return of the repressed. By 1936 Anna Freud (1936), his daughter, was able to list nine mechanisms of defence (regression, repression, reaction-formation, isolation, undoing, projection, introjection, turning against the self, and reversal). She added a tenth normal mechanism (sublimation) and one or two more (such as idealization and identification with the aggressor). Melanie Klein emphasized the defences of splitting and projective identification (Segal, 1964) occurring in both normal and abnormal development.

Further development of the concept of defences has taken place over the years. In contrast to this classical picture, relational models see defence mechanisms as a protective shield within which the authentic self is held: Defences form part of the attempt to facilitate the development of a 'true' (Winnicott, 1965) or 'nuclear' (Kohut, 1971) self in the face of a defective relational environment. In keeping with Freud, clinicians consider some uses of defence as developmentally necessary. The boasting of the little boy becomes a powerful force in overcoming inferiority and attaining manhood; omnipotent and paranoid defences, rather than avoiding inherent destructiveness or innate division and conflict, are desperate attempts to overcome and recover from states of terror and despair resulting from environmental failure.

Bowlby reframed defences in interpersonal terms, basing his view on attachment theory (Holmes, 1993). Secure attachment provides a positive primary defence whilst secondary or pathological defences retain closeness to rejecting or unreliable attachment figures. In 'avoidant attachment' both neediness and aggression are split off and the individual has no conscious knowledge of the need to be near the attachment figure, appearing aloof and distant; whilst in 'ambivalent attachment', omnipotence and denial of autonomy lead to clinging and uncontrolled demands. For clarity we follow a more classical exposition in discussing the specific defences often referred to in the literature. Our list of defences that follows is not exhaustive but made up of those we find ourselves thinking of most commonly in everyday clinical work.

Repression

As described at the beginning of the previous section, we all at different times *suppress* inconvenient or disagreeable inner feelings,

or totally *repress* what is unacceptable to consciousness. Commonly suppression is considered to be mostly a conscious act whilst repression takes place outside awareness. There is nothing abnormal or pathological about either of these processes, unless carried to extremes. Before the days of anaesthetics, a sensitive surgeon had consciously to ignore and then suppress feelings about the screams of patients in order to be effective. In extreme cases though, people who declare they have never felt angry or sexually aroused may be severely repressed.

The concept of repression has been brought back into focus more recently with the controversy surrounding recovered memories of abuse. The issue has been polarized by labelling the memories as true or false, recovered, or discovered. False or pseudo-memory implies that all of these memories are untrue and based on fantasy or wish fulfilment. Recovered memories imply that the memories are accurate and have been 'stored' in the unconscious only to be uncovered by therapy. Others have labelled the memories as discovered memories to attempt to neutralize the controversy.

As our knowledge about memory has become more extensive, so also has the complexity of the debate. Selective forgetting is a well-known phenomenon of the memory system, retrieval of memory can occur for the first time long after the event, anxiety and trauma interfere with the storage of memories, and the motivated distortion of recall has become a central component of cognitive theories and behavioural accounts of psychopathology. Of course, as in any debate, there is also evidence that memories can be remembered clearly but be proven false. One well-known personal pseudo-memory was described by Piaget, the well-known Swiss developmental and cognitive psychologist. For many years Piaget described a clear visual memory of someone trying to kidnap him from his pram when he was 2 years old and of his nanny chasing away the kidnapper. Years later, when Piaget was 15, the nanny returned to the Piaget family and confessed that the incident had never occurred. Her motive in reporting the event had been to enhance her position in the household, but she subsequently suffered guilt about the fabrication and about the watch she had received as a reward (Piaget, 1962). So the question is not so much related to whether or not repression exists but more about what its role is as a hypothetical psychological process in psychological disturbance and the functioning of memory.

Denial

We may deny or forget unpleasant external events: for example, an unhappy affair or an examination failure. It has been reported that, following bereavement, up to 40 per cent of widowed people experience the illusion of the presence of their lost spouse and 14 per cent actually imagine they have heard or seen the lost partner (Parkes, 1972). This could be seen as a form of denial of a painful loss which is fairly normal, that is, common in exceptional circumstances. The experience of a phantom limb following amputation (sensations suggesting the limb is still there) may have neurological origins, but may also be understood in the same way as a denial of the loss. This view is supported by reports that phantom limb is experienced more commonly after sudden and unexpected amputation (e.g. following a road accident) than when there has been time to prepare for it psychologically. Both these examples illustrate the difference between repression and denial. In contrast to repression, which aims to remove an aspect of internal reality from consciousness, denial or disavowal (Freud, 1940) deals with external reality and enables an individual to repudiate or to control affectively his response to a specific aspect of the outside world. Denial involves splitting of the mind in which there is cognitive acceptance of a painful event while the associated painful emotions are repudiated. The protective aspect of denial is illustrated by Greer, Morris, and Pettingale's (1979) finding that women with breast cancer who showed denial (or defiance) when told the diagnosis, following mastectomy, had a significantly higher survival rate than women who reacted with hopelessness or depression.

Projection

We commonly externalize unacceptable feelings and then attribute them to others: 'The pot calling the kettle black.' Christ knew this well: 'Why beholdest thou the mote that is in thy brother's eye, but considerest not the beam that is in thine own eye?' It must be as old as time to blame our neighbours, or neighbouring village, tribe, country, etc., for our own shortcomings. This is a normal though tragic and dangerous human trait. In extreme forms it amounts to paranoia, for example, when individuals disavow their own hostile or sexual feelings but declare that others have hostile or sexual designs upon them. This is manifest in the extreme in paranoid psychoses, delusional disorders, and erotomania, for example.

Sometimes people behave as though not only feelings but important aspects of their own selves are contained in others; for example, the mother who unconsciously deals with the deprived-child part of herself in caring for her baby may spoil it and prevent it growing towards greater independence. This helps mother to cope with the pain of her own frustrated longing for closeness and dependence, but the baby's developing needs may be thwarted by mother seeing in the child an aspect of herself and provoking the child to enact it. In the technical language of Kleinian psychoanalysis this is an example of projective identification (Sandler, 1987).

Closely associated is the phenomenon of splitting, which involves the complete separation of good and bad aspects of the self and others, as illustrated by the perennial interest of children in heroes and monsters, good fairies and witches (Bettelheim, 1975). Clinically we see it in splitting between good and bad feelings, between idealization and contempt of self and others.

Splitting and projection are considered to be behind many of the symptoms which are characteristic of borderline personality disorder and other severe personality disorders (Kernberg, 1984). Dynamic therapy has been modified for these conditions (see p. 235) according to this understanding and focuses on the consequences of excessive use of splitting and projection (Kernberg, Clarkin, & Yeomans, 2002).

Reaction formation

Reaction formations go to the opposite extreme to obscure unacceptable feelings. They may be highly specific, for example showing excessive deference to someone whom one hates or caring excessively for others when one wishes to be cared for oneself, or more generalized, in which case they form part of a character trait. Conscientiousness may be an example of this when associated with obsessional personality; excessive precision and tidiness may hide a temptation to lose control and to be messy. Extreme cleanliness may have its usefulness, for example, 'scrubbing up' in an operating theatre. Out of context it can be crippling, for example in obsessional neurosis where many hours a day may be spent in

washing rituals. The psychodynamic view of such obsessional states is that hostile feelings are usually being concealed.

Reaction formation is related to identification with the aggressor which Freud (1920) had alluded to when describing the behaviour of a child towards an adult in which there was a total submission to the adult's aggression and a resulting internalization of profound feelings of guilt related to the inwardly directed aggression. But it was Anna Freud (1936) who described the mechanism in detail. Since then it has often been known as the Stockholm syndrome after the siege in Stockholm in which bank robbers held bank employees hostage for 6 days in 1973. In this case, the victims became emotionally attached to their victimizers, and even defended their captors after they were freed from their 6-day ordeal.

Rationalization

An example of this has already been given in discussing post-hypnotic phenomena (p. 20) when the subject justifies an unconscious impulse and is unaware of its source. Our idiom 'sour grapes' is a further example deriving from Aesop's fable of the fox who could not reach the grapes and consoled himself with the rationalization that they were sour anyway. In other words an individual gives himself a logical and plausible explanation for what is happening or for irrational behaviours that have been prompted by unconscious wishes. Not surprisingly this mechanism is common in politics, business, and medicine when things go wrong. Sometimes this is differentiated from intellectualization in which emotional anxiety is managed by cognitive appraisal. For example a young person anxious about sexual performance might discuss the morality of pre-marital sex with a friend rather than mention his underlying anxieties.

Conversion and psychosomatic reactions

Unacceptable feelings or affects may be converted into physical symptoms as in hysterical conversion or psychosomatic disorders. We have already given a classical example of hysterical conversion above (p. 19). Such hysterical disorders are becoming increasingly uncommon in developed societies, almost as if people now know that the deeper meaning would be rumbled. On the other hand, psychosomatic disorders have gained increasing attention in recent years. Bottling up of rage may, for example, contribute to an attack of migraine.

> *A conscientious but inhibited nursing sister could never express her exasperation with her junior nurses whenever they made a silly mistake, for fear she would be too destructive. On such an occasion she would bottle up her rage and typically have an attack of migraine later that evening. During the course of psychotherapy she became more in touch with her anger and more able to express it. One day she reported that she had been able to tell off a nurse at fault and was surprised but delighted to find that no migraine had then followed.*

In hysterical conditions there may be a symbolic element to the symptoms, which hints at an underlying fantasy, as in the example of the girl whose paralysed arm represented a defence against her wish to hit her therapist (p. 19). Psychosomatic disorders are now less often thought to have this symbolic significance, but to occur in those restricted in their fantasy life, whose emotions are expressed physically and whose thinking tends to be concrete and conversation circumstantial. The word 'alexithymic' has been introduced to describe such people who have no words for their feelings (Nemiah, 1978). These qualities are now recognized as occurring in post-traumatic states and in some people with addictive problems and sexual problems, as well as those prone to psychosomatic disorders and reactions (Taylor, 1987).

Uncertainty remains about the underlying psychological processes involved in hysterical conditions and psychosomatic disorders. The descriptive term somatization disorder is now often used and is part of the official classification system for the *Diagnostic and Statistical Manual for Mental Disorders* (American Psychiatric Association, 1994). Patients have a history of many physical complaints, including symptoms of pain, gastrointestinal complaints, sexual symptoms, and pseudo-neurological complaints, all with no clear medical explanation. The overlap with hysteria and character problems is well described and the presence of histrionic personality traits, conversion and dissociative symptoms, sexual and menstrual problems, and social and interpersonal impairment (Cloninger, 1994) suggests that unconscious determinants are important, especially as the affected individuals are genuinely distressed and experience terrible psychological anguish.

Displacement

When we are too afraid to express our feelings or affects directly to the person who provoked them, we may deflect them elsewhere. A cartoon example is the office hierarchy: the boss is angry with his next-in-command, who in turn takes it out on the one beneath him, and so on till the office boy is left kicking the office cat. The phenomenon of displacement is widespread in other animals and known to ethologists as re-direction. A common type of displacement is the 'turning on the self' of affects such as anger, as seen in self-destructive behaviour and masochism; it is particularly prominent in depressive conditions and suicide attempts.

Regression

It is perfectly normal and indeed desirable on holiday to abandon our more usual adult responsibilities and go back (regress) to the less mature joys of childhood, such as swimming, games, etc. In the face of disasters with which we feel unable to cope – such as severe illness or accidents – we may also regress to more child-like and dependent ways of behaving. Then we look for adults or leaders in whom we can repose our trust (see Transference, p. 70), although this may also leave us vulnerable to domination by demagogues.

Sleep might be seen as a normal daily form of regression from the challenges and responsibilities of waking life. A child who has achieved bladder control may, following the birth of a younger sibling, regress to bed-wetting again. The condition of anorexia nervosa (severe weight loss and amenorrhoea in teenage girls caused by dieting) can be partially understood as a retreat from the difficulties of coping with adolescent sexuality (Crisp, 1967).

Depersonalization, confusion, and dissociation

These are terms with a well-recognized meaning in general psychiatric phenomenology. Depersonalization is the name given to a state in which someone feels to be outside himself, as if separated from his feelings and from others by a glass screen, like an outside observer of his own mental processes or body; this may occur in any psychiatric state but is a special feature not surprisingly of anxiety disorders and depersonalization disorder and other

dissociative disorders. Confusion, in contrast, is the term given to a state of disorientation in time and place, in which the subject may not know the date or where he is; this is the hallmark of an organic psychiatric state due to underlying somatic cerebral dysfunction.

However, although these are both well-accepted terms in general psychiatry, which we do not wish to challenge, patients much more often complain of feeling confused when they have no such organic state. They are usually in intense conflict between opposing feelings, say of love and hate, and confusion has descended like a sort of defensive fog to deal with the unbearable conflict. This mechanism operates in many cases of depersonalization. Like confusion (in our sense), depersonalization occurs during intense emotional arousal and the subject may notice quite a sudden moment of 'switching off' of feelings within himself and a withdrawal from the outside world. This is also known as pretend mode functioning (see p. 84). There is evidence from psychophysiological studies in line with this; measures of arousal suggest abnormalities of stress-response systems, which may themselves be a cause of some of the symptoms but equally might be the result of the dissociative processes (Giesbrecht, Smeets, & Merckelbach, 2007; Simeon, Knutelska, & Yehuda, 2007). Dissociation is a hypothetical mental process, like repression, that disrupts connections between a person's thoughts, memories, feelings, actions, or sense of identity. It is a normal response to trauma, and allows the mind to distance itself from experiences that are too much for it to process at that time. Dissociation is still encountered in clinical practice, occurring in cases of hysterical fugue or amnesia. In war-time, a soldier might come wandering back from the front line in a fugue state having had to obliterate the intolerable memory of seeing all his comrades killed by a shell. In peace-time, a person may appear in a casualty department declaring that he does not know his name, address, or anything about his past life. This may have followed some imbroglio or misdemeanour, such as hitting his wife in a row or being discovered committing a fraud, the emotional consequences of which cannot be faced because of the shame and blow to self-esteem involved.

Sublimation

This was defined by Anna Freud (1936, p. 56) as, 'the displacement of the instinctual aim in conformity with higher social values'. It is

the most advanced and mature defence mechanism, allowing partial expression of unconscious drives in a modified, socially acceptable, and even desirable way; for example, murderousness may be given a partial outlet in work in abattoirs or in field sports. The suggestion often made by older people that restless or aggressive young men should be made to join the army for a time suggests that sublimation as an idea has cultural acceptance. The drives (p. 39) are diverted from their original primitive and obviously aggressive and sexual aims, and are channelled into a 'higher order' of manifestation.

> *An intellectual young man of 18, brought up in an emotionally confusing family, was outwardly very inhibited and unassertive. His pleasure in self-display, competition, and sexual curiosity were so stunted by conflicts that he avoided girls and was shocked to read a biological account of reproduction at 16. However, from an early age he had built up a remarkable collection of tin soldiers, and was fascinated by the flamboyant costumes of historic times. They seemed to give expression to the otherwise repressed but healthy parts of himself. Until he worked through his neurotic inhibitions, his curiosity and his exhibitionistic and competitive impulses were dealt with as though intolerable except in this indirect and sublimated form.*

Beyond neurosis, sublimations enrich both individuals and society. Freud saw culture as a sublimation of our deepest and darkest urges as well as an embodiment of our highest aspirations, as in sport or drama. The writer Kafka (1920) said something similar in an aphorism: 'All virtues are individual, all vices social; the things that pass for social virtues, such as love, disinterestedness, justice, self-sacrifice, are only "astonishingly" enfeebled social vices.'

Vital parts of an individual may only be expressed in dreams or pastimes. Through cultural activities we can participate indirectly and vicariously in propensities otherwise unexpressed; carnival is a time-honoured example. A society's culture is the outcome of its life at all levels, from instinctual roots to highest ethical ideals; unconscious drives press for expression. Social defences develop to channel this expression and reduce associated conflict and anxiety.

MOTIVATIONAL DRIVES

Any attempt to understand the springs of human behaviour in all its complexities in both health and disease must, sooner or later, confront the problem of human motivation. Dramatists, novelists, and poets were exploring the fields of human love and hate, heroism and destructiveness, long before scientists began to turn their attention to such concerns. Clearly there are many types of innate behaviour, from simple in-built reflexes to complicated patterns which depend more on learning, such as maternal caring behaviour. There are also basic physiological needs for air, food, and water, which, if not satisfied, lead to powerfully motivated behaviour. But ordinarily, in contemporary Western society, we are not deprived of such needs and they do not give rise to conflict. We are concerned more with those areas of motivation where conflict does arise.

In talking about motivational drives we come immediately to a central problem for the language of psychotherapy (Pedder, 1989b), which is the same whenever we try to grapple with the mysterious relationship between psyche and soma (or mind and body). From the side of the psyche we can use the language of human experience and speak of urges or wishes; from the side of the soma we can talk like biologists or scientists about instincts or drives. Sandler and Joffe (1969) distinguished between the experiential and non-experiential realms. In the experiential realm lie all our sensations, wishes, and memories: all that we 'know' through subjective experience, whether conscious or unconscious, at any given moment. By contrast, the non-experiential realm of instinct and drive remains intrinsically 'unknowable'.

Instinct has been defined as 'an innate biologically determined drive to action' (Rycroft, 1972). The term has been in use since the sixteenth century and derives from the Latin for impulse (*Shorter Oxford English Dictionary*). In the nineteenth century the notion of an instinct or drive was coloured by the language of the physical sciences and seemed to convey the oversimplified idea of hydraulic pistons pushing an animal forward. Nowadays biologists prefer to speak of innate patterns of potential behaviour, acknowledging their greater complexity. Such patterns, or 'motivational systems' (Rosenblatt & Thickstun, 1977), require particular external triggers or releasers for their activation. Yet at times we do still subjectively experience our drives or impulses as welling up from inside us,